THE Canadian Hospital

A Monthly Journal for Hospital Executives

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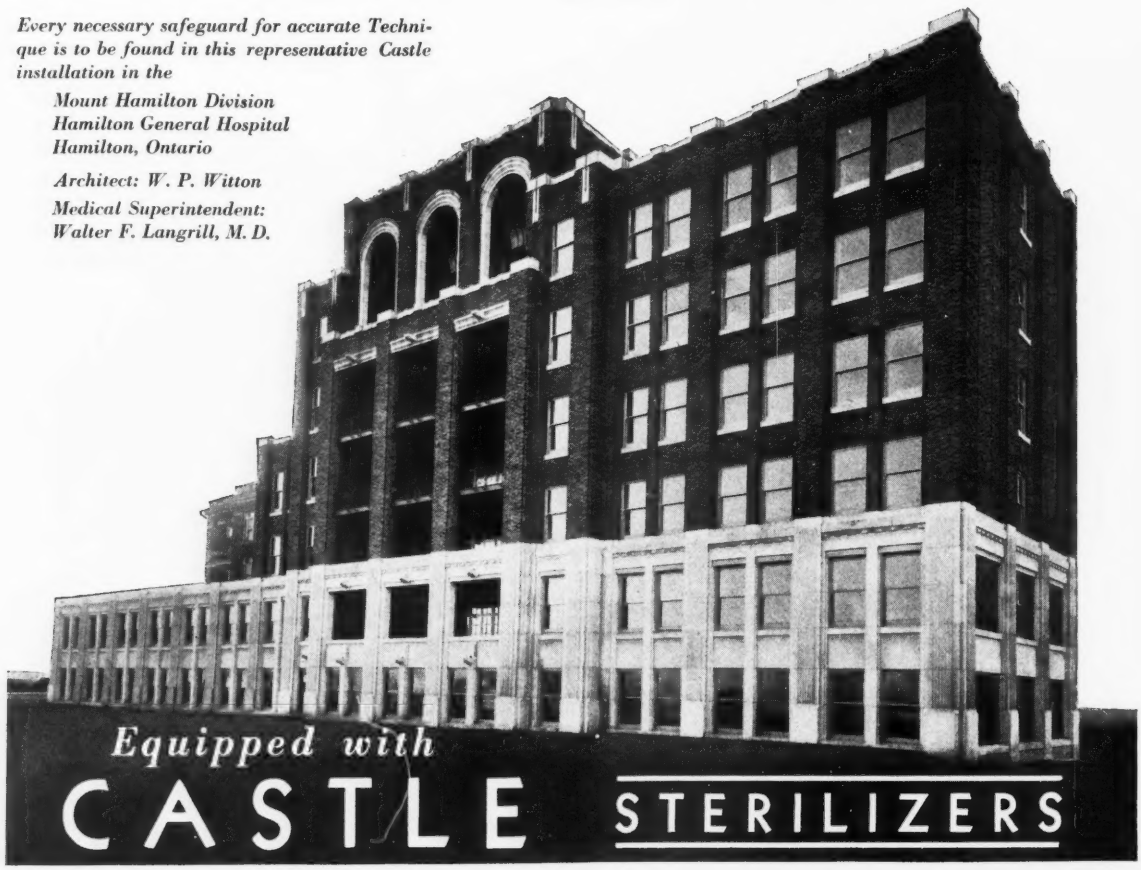

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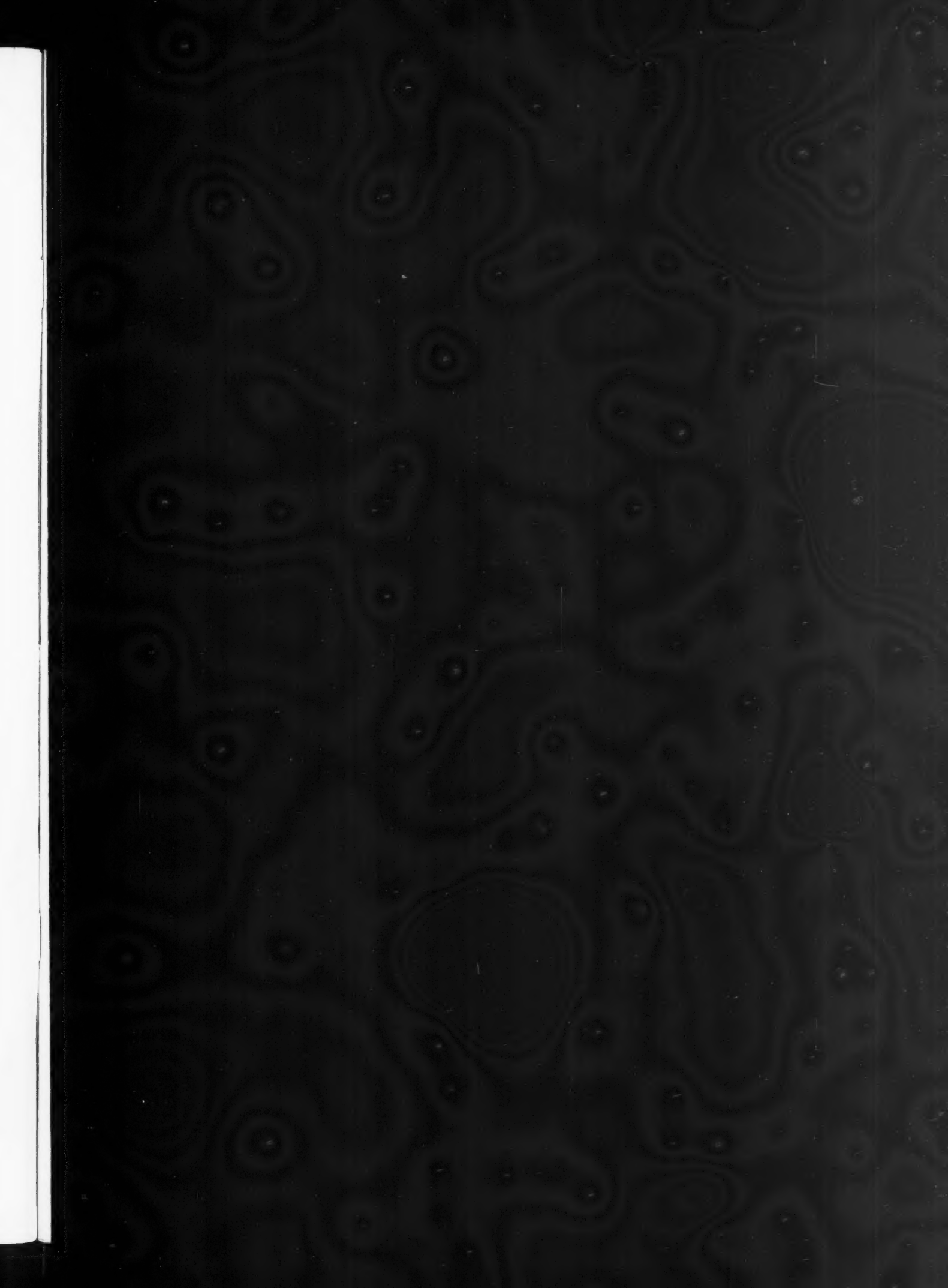


Organization and Management of a Department of Anaesthesia in a 200 to 400 Bed Hospital

B. C. LEECH, M.D., C.M.,
Director, Department of Anæsthesia, Regina General Hospital,
Regina, Sask.

THE observations and suggestions here presented are based upon experiences gained in four years operating an organized anæsthetic department in a hospital of 410 beds, 160 of which are definitely surgical beds,—but would apply, I am sure, to any hospital of over 200 beds.

The advisability or advantage of having an anæsthetic department in every modern hospital of any size is universally appreciated, and need not occupy our consideration here, except to say that wherever such an organized department exists, it has proven to be an institution of great assurance and convenience to the surgeon; of uniform good service to the patient, and of pride and protection to the Board of Governors.

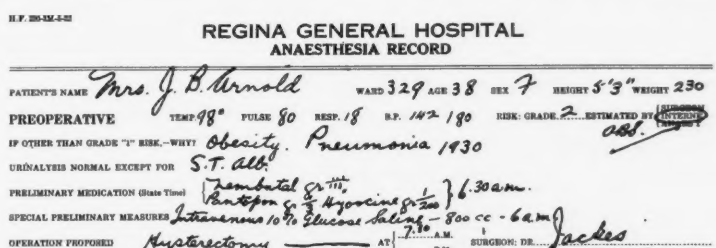
Organization

The anæsthetic staff should consist of a Director, who is responsible to the Hospital Superintendent and who is a perennial member of the standing surgical committee of the medical staff of the hospital; an assistant director ready to take charge in the absence of the director; two, at least, associate anæsthetists; and the hospital intern anæsthetists. It may here be noted that nurse-anæsthetists have not been included. This is because nurses are not legally permitted to practice anæsthesia in our part of Canada. I would presume, however, that if such were employed they would probably have the status of intern-anæsthetists in the scheme of things.

Personnel and Duties

The Director: Must be a qualified and licensed doctor. He, or she, must be well trained and skilled in all forms of anæsthesia and thoroughly familiar with all types of anæsthetic apparatus. He must have ability as a teacher and manager, and a natural bent for clinical, statistical and scientific investigation. He should restrict his medical practice to the strict specialty of anæsthesia—first, because anæsthesia is rapidly becoming more and more technical, and its importance is occupying more and more attention in the minds of both the surgeons and the public; so that reading and research must occupy a great deal of a director's time; and, secondly, for the sake of recognition and complete co-operation from the surgeons he should not be engaged in any sort of competitive or opposition practice. If he is properly equipped he can supplement his hospital work by doing dental and obstetrical anæsthesia; and in many hospitals he also becomes the oxygen-therapy expert.

His duties involve the responsibility for his staff and equipment. He must personally train and supervise the members of his staff and pass judgment on the ability of each member to handle each anæsthetic procedure. He is personally available for anæsthesia and for pre-operative and post-operative consultations on any anæsthetic problem or complication. He should arrange that each patient be carefully categorized pre-operatively as to anæsthetic or operative risk. He should be the judge of the suitability of the anæsthetic method to be employed for each operative case, and should allot definitely each anæsthetic to a particular member of his staff, or to himself. Furthermore, he must personally, and in writing, order whatever pre-anæsthetic



(Figure 1)

Read before the American College of Surgeons Sixteenth Annual Hospital Standardization Conference, Chicago, Oct. 10th, 1933.

medication might be required for every patient. A convenient and dependable method of carrying out these important details will be described later. And finally, he should prepare annually a detailed analytical report covering all hospital anæsthetic experience, showing numbers and types of anæsthetics given, successes and failures, anæsthetic complications and deaths for the preceding year. Such a report should be presented to a meeting of the Medical Staff Society, and there be fully considered and discussed.

The Assistant, or Deputy Director: Is actually one of the associate anæsthetists who understands thoroughly the workings of the department, and who is ready to take full charge in the absence of the Director.

Associate Anæsthetists: In every community are to be found a few young medical men who are breaking into practice—usually rather slowly—and who have had recently a good general hospital internship, including good general anæsthetic training. Many of such men, especially while working up a private practice, welcome the opportunity of an associate appointment in a well-organized department of anæsthesia, and several of them may later turn to a purely anæsthetic specialty. All of these men are good, dependable, general anæsthetists, and each is encouraged to make a particular hobby, both in practice in research, of one particular type or method of anæsthesia. The associates form a pillar of strength to the anæsthetic department, because when the director is himself occupied, they can with assurance and authority be assigned to take charge of private-ward or poor-risk public cases, rather than having such responsibilities fall unfairly upon the shoulders of interns.

Intern Anæsthetists: The intern organization of every hospital of over 200 beds should provide that two interns (a senior and a junior) be always available for anæsthetic duty during the regular operating hours; and that two others who are mainly on other services be available when required as third and fourth call intern anæsthetists. And during all other hours of the day and night, one of the above must be available for emergency anæsthetic calls. The senior intern-anæsthetist is one usually who has had previous experience in the department as second or third-call man. He is made responsible for the maintenance of anæsthetic records and reports.

The director must concentrate upon these four men in order to make their anæsthetic service of value both to themselves and to the hospital. He must give lectures and demonstrations to these men, have them observe his work and sit in with them frequently on their work. And he must insure that no intern is left to undertake alone any procedure in which he is not previously experienced and competent.

Usually the intern's period of anæsthetic service is two or three months, but of course he may return to the department in some slightly altered capacity in the course of his rotation service. Thus it may readily be seen that it is not long before there are several dependable intern anæsthetists ready to cope with most ordinary demands and most emergency cases.

Anæsthetic Records and Statistics

I should like to briefly outline a system of anæsthetic recording which after many revisions has come to be regarded as both simple and satisfactory, and one which may easily be re-adjusted to cover any desired line of statistical research.

The illustration (Figure 1) shows what we have found to be a very satisfactory, complete and simple form of anæsthetic chart. It is printed on blue paper so as to be readily distinguishable on a patient's file from the reports of other hospital departments, each of which has a distinctive colour. It has three subdivisions, headed—"Preoperative," "Operative," and "Post-Operative."

The "Preoperative" portion of the chart is the responsibility of the ward intern (not the anæsthetic intern). He must make an investigation and examination of each case and fill in the required information for the benefit of the

ANAESTHETIC RECORD BOOK. Suggested Synoptic Headings.

Date	Name	Ward	Surgeon	Anaesthetist	Risk	Operation	Upper / Lower } Abd.	Anaes. Agent	Method	Induction Agent	Preliminary Medication

Induction Period	Maintenance Period	Condition at Close	Stimulation	Nausea	Op. Time: Hrs.	Op. Time: Min.	Gas	Oxygen	Amt. Used	Spinal	Other	Anaes. Chgs.	Fees	Remarks

(Figure 2)

R.F 229—1M-1-32

REGINA GENERAL HOSPITAL

Date Aug 15/33

ANAESTHETIC CHARGE RECORD

Patient	Ward	Anaesthetist	Gas	Oxygen	Regional Agent	Fee	Total Charge	Remarks
Mrs J.B. Arnold	329	B.C. Leech	—	.50	1.30	18.00	19.80	
Mr P. Anderson	226	—"—	2.25	.25	—	—	2.50	Public.
P. Stanzisky	116	H. Spooner	—	—	.65	—	.65	Pub.
Mr. N. Lucas	208	C.R. Mary	—	—	1.30	15.00	16.30	
Evelyn Murdoch	101	B.C. Leech	1.00	.25	—	8.00	9.25	
Miss J. Sproule	300	O'Brandon	4.00	.50	—	—	4.50	Pub
J. W. Snedger	121	H. Spooner	—	.25	1.30	—	1.55	Pub.
Miss E. Stanford	340	B.C. Leech	4.50	.50	—	—	(5.00)	Nurse in Training
Mrs. C. Peterson	314	S.R. Conn.	—	.25	.65	10.00	10.90	

(Figure 3)

anæsthetic department. Further, he must notify the surgeon concerning any unexpectedly substandard risk. No anæsthetic is allowed to be administered unless the patient has been graded as to anæsthetic and operative risk —and thus we have it staring the anæsthetist in the face as soon as he picks up the patient's chart in the operating room. It is a matter of pride and great satisfaction that this system, followed in toto only for the past twelve months, has more than justified its institution.

We have found the most workable and simple system of categorizing pre-operative risks is to grade them as follows:

Grade 1—Good risks.
Grade 2—Questionably good risks.
Grade 3—Poor risks.
Grade 4—Very dangerous risks.

After a very little instruction and experience, interns find it usually a rather simple matter to estimate patient's chances, according to this simple preoperative categorization.

By a certain hour each evening these actual forms, with the preoperative portion filled in and initialled, reach the night supervisor's office and are available for the chief anæsthetist. He can then call at the hospital and with intelligence can select the anæsthetic procedure, assign a suitable anæsthetist, and order proper preliminary medication for each case scheduled for the next morning.

The "Operative" portion of the chart, when conveniently filled in by the anæsthetist, gives a "running story" of the anæsthetic and operative period. This, of course, is more or less similar to all other charts, and accurate notations on such a chart are valuable from both medico-legal and clinical standpoints.

The "Post-operative" portion of the form is the responsibility of the ward nurse, or the special nurse, and is finally completed at the end of hospitalization. This is of great help to the record office in preparing post-anæsthetic or post-operative statistics.

A duplicate carbon copy of the anæsthetic form is kept up to the close of the operation. It is then detached from the patient's chart and placed on the chief anæsthetist's desk, at the same time as each anæsthetist makes his entry on the daily anæsthetic charge sheet. Then at the close of each day's operations the senior anæsthetic

REGINA GENERAL HOSPITAL

POST-OPERATIVE COMPLICATIONS
WEEKLY REPORT

Ward F Week Ending Aug 12 1933

	NAME: Mrs S. Jones	NAME: Mr T. Kelly	NAME:	NAME:
HOSP. NO.	5472	5643		
DOCTOR:	Johnston	Harvie		
OPERATION:	Gastroenterostomy	Leg Amputation		
DATE OF OPERAT.	Aug 2.	Aug 7.		
ANAESTHETIC:	Spinal & Gas-Oxygen	Spinal		
ANAESTHETIST:	Dr Smith	Dr. White.		
COMPLICATION:	Productive Cough	Wound Infection		
OUTCOME OF COMPLICATION:	Complete Recovery	/		
REMARKS:	Previously Reported	/		

DATE: Aug 13th 1933

SIGNATURE OF HEAD NURSE: S McRae

(Figure 4)

MONTHLY AND ANNUAL ANAESTHETIC STATISTICS—1932

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Yearly Total
Total Operations	269	243	314	257	274	287	295	315	248	236	243	264	3245
Anaes. (Non-local)	203	193	245	197	208	207	243	257	196	208	192	199	2548
Anaes. by Interns	75	97	120	77	75	18	94	137	98	91	110	123	1085
TYPES													
Chloroform	9	3	4	9	3	4	5	8	3	3	1	8	60
C. & E.	3	3	14	3	12	3	1	3	12	6	5	8	73
Ethyl Chloride	0	2	2	0	1	1	3	4	4	3	1	0	21
Ether—Open	147	158	145	122	115	102	155	191	140	141	137	150	1703
Intrapharnygeal	2	0	1	1	2	1	1	1	1	2	2	1	15
Intratracheal	7	0	3	3	0	3	0	0	2	3	1	0	22
Ether—Total	156	158	149	126	117	106	156	192	143	146	140	151	1740
Nitrous Oxide—Oxygen	5	6	23	18	5	14	8	15	17	16	23	16	166
Intratracheal	1	0	1	1	0	0	0	0	1	1	0	2	7
And Ether	0	6	5	2	0	4	5	2	6	2	4	7	43
Gas—Oxygen Total	6	12	29	21	5	18	13	17	24	19	27	25	216
Avertin—Rectal	0	5	3	1	0	0	1	1	0	1	0	0	12
Spinal—Novocaine	36	31	53	31	15	23	24	30	32	34	50	42	401
Stovaine	6	4	1	3	1	2	1	3	2	1	0	0	24
Spinal Total	42	35	54	34	16	25	25	33	34	35	50	42	425

(Figure 5)

intern enters the required details of each case in the permanent anæsthetic record book. This book is in synoptic form and is ruled off into many columns, headed up according to statistical requirements (Figure 2). From this book many monthly and annual statistical reports are prepared which are presented annually in analytical form to the hospital medical staff for consideration.

Figure 3 shows a convenient form of daily anæsthetic charge sheet which goes to the accounts office, where corresponding charges are entered on patients' accounts, and credit entries are made in each anæsthetist's journal, except, of course, in the case of salaried anæsthetists.

While the anæsthetic record book gives us all the desired statistical information up to the close of the operation, we must look elsewhere for information regarding post-anæsthetic sequelæ and complications. Such information is gathered in two ways. First, a permanent list is made, when charts reach the records office, of all post-operative complications. Then it is a simple matter for the director of the department of anæsthesia to select those cases which may be post-anæsthetic in nature and consult the actual charts where necessary in preparing his annual statistical report. Secondly, early and often valuable information may be easily made available by having each nurse in charge of a surgical ward send in a weekly return (including "nil" returns) of all post-operative complications in her ward, (Figure 4). By scanning all these reports each week, one may detect early any errors in anæsthetic or surgical technique before further damage is done. For example, this system, one week, showed four cases, spread over various wards, of headache and backache following spinal block analgesia. We had not had such complications before, and a hurried investigation revealed that certain operating rooms had been supplied with new lumbar puncture needles of too large a bore, and with too sharp a point, permitting subsequent leakage of cerebro-spinal fluid from the spinal canal (giving headache) into the soft tissues of the back (giving backache). This was at once corrected, and there was no such recurrence. Another example of the value of some such system was that post-operative skin burns spotted throughout the hospital, one week, led to the discovery of faulty technique on the part of one or two individuals in the matter of surgical preparation of patients. In other words, such a system of regular and early reporting is a safeguard against letting any error go uncorrected. It further informs the anæsthetist, while it exists, of any complications which he may wish to personally investigate, such as pneumonia, etc.

There is probably no better way of learning one's own business thoroughly than by preparing and analyzing an annual statistical report of that business and talking over the accomplishments, successes and failures with others who are directly interested. Figures 5, 6 and 7 show a very imperfect (though to us a readily edifying) attempt in this direction.

The only regrettable feature of preparing such statistics is that when one finishes, and looks about for similar reports from elsewhere with which to compare his own results, he unfortunately finds that very few such reports are published. And each of those few is compiled in some different manner to his own, so comparisons are therefore difficult or impossible.

If the science and art of anæsthesia are to advance much further for the benefit of mankind, they must do so with the help of the honest, intelligible, and uniform reporting of the anæsthetic experiences of all first class hospitals, and by the amassing of all such statistics into one great annual report. It is my prayer that some capable organization be early instituted to bring this about.

Financing a Department of Anæsthesia

Since this is a Convention of hospital administrators, the subject of financing an organized department of anæsthesia should receive some brief comment.

Regarding anæsthetic materials, any that are expensive, such as the anæsthetic gases and spinal preparations, etc., should definitely be charged to the patient, allowing sufficient profit to permit their use, when indicated, for the non-paying patient, and also to gradually pay off the purchase price of expensive anæsthetic apparatus. But ordinary agents, such as ether, chloroform and ethyl chloride, should not bear a separate charge, but should be absorbed in the operating room fees.

Intern anæsthetists do not require any consideration as

THE ANAESTHETIC PERIOD
(Reporting 1475 Observed Consecutive Administrations)

	Induction—Difficult or Unsatisfactory:	Stimulation on Table	At Termination—Any Degree of Shock:
Chloroform	1:29 = 3.45%	0.29	2:29 = 6.89%
C. & E.	17:57 = 29.82%	1:57 = 1.75%	4:57 = 7.02%
Ethyl Chloride	0:2	0:2	0:2
Ether	79:890 = 8.87%	14:890 = 1.58%	33:890 = 3.71%
Gas-Oxygen	8:178 = 4.44%	4:178 = 2.24%	7:178 = 3.74%
Avertin	10:12 = 83.33%	3:12 = 25.00%	2:12 = 16.66%
Spinal: Difficult 8			
Part. Fail 2			
Comp. Fail 1	11:309 = 3.56%	30:309 = 9.70%	13:309 = 4.20%
Total—All Types	126:1475 = 8.54%	52:1475 = 3.52%	61:1475 = 4.14%

(Figure 6)

regards financing, as they go through the department in the course of a rotation intern service.

Associate anæsthetists are probably best compensated by having their fee added to the patient's hospital bill and transferred to their credit if and when paid.

The Director of the Department can be financed in one of two ways. First, by the Hospital collecting and retaining his fees and paying him a salary under contract. In this case it is probably best to allow him schedule of percentage bonusing of profits earned and collected above and beyond his salary. The man on flat salary tends to lose ambition and get into a rut of indifference.

The other system is that the Hospital collect his fees and turn them over to him when collected, having a monthly accounting of same. Here some minimum income should be guaranteed by the hospital, especially in starting off with a newly formed department. Here, further, probably some modest honorarium should be paid the director for his extra time spent in training interns and generally supervising the department outside of his own cases. More can thus be expected of him than otherwise.

Either system has advantages and disadvantages to both the hospital and the anæsthetist concerned, and I am not yet convinced that one is more satisfactory than the other. Whatever the system of finance, it should be such that will permit the director to have at least one month per year to travel and visit anæsthetic departments and conventions elsewhere, so that he may keep himself and his staff abreast of modern developments.

Summary

1. An anæsthetic department should consist of a full-time director, part-time associate anæsthetists, and interns.

2. The director must be responsible for the training of his staff, maintenance of equipment, assignment of cases, preliminary medication, keeping of records, and the presentation of an annual analytical report of his department's work.

3. Careful pre-operative categorization of every case as to risk is imperative.

4. Every hospital of any size can operate a good anæsthetic department at no additional cost.

5. A good Department of Anæsthesis should be an important component of any hospital of over 200 beds. It soon becomes a matter of pride to any good hospital, and of attractive and comforting assurance to the whole community, especially, of course, to the surgical patient himself.

1932 TOTAL HOSPITAL POST-ANAESTHETIC COMPLICATIONS:
(TOTAL ANAESTHETIC CASES 2,548)

Administration:	Agent:	Deaths:	Pneumonia:	Minor Respiratory:	Total Respiratory:	Severe Distention:	Excessive Vomiting:	Severe Tachycardia:	Total Casualties:
1611	Ether	On table—2 Post-op.—1 = 0.18% TOTAL —3	3 = 0.18% (1 death) (2 recoveries)	20 = 1.24%	23 = 1.43%	2 = 0.12%	3 = 0.18%	0	30 = 1.86%
396	Spinal	On table—3 Post-op.—2 = 1.26% TOTAL —5	1 = 0.25% (Died)	7 = 1.76%	8 = 2.02%	2 = 0.50%	0	2 = 0.50% (1 died) (1 recovered)	15 = 3.78%
203	N_2O Oxygen	0	0	0	0	1 = 0.49%	0	0	1 = 0.49%
13	Avertin	0	0	1 = 7.62%	1 = 7.62%	0	0	0	1 = 7.62%
110	Chloroform: C. & E.; Ethyl Chloride—No complications.				0	0	0	0	0
2333	All types	On table—5 Post-op.—3 = 0.34% TOTAL —8	4 = 0.17%	28 = 1.15%	32 = 1.37%	5 = 0.21%	3 = 0.12%	2 = 0.08%	47 = 2.01%

ANALYSIS BY DEATHS:

ETHER CASES—ON TABLE (2)

1 Haemorrhage into trachea with drowning. (Pre-Operative Risk Grade 3.)
1 Marked Status Lymphaticus. (Pre-Operative Risk Grade 1.)

ETHER CASES—POST. ANAES. (1)

1 Acute Broncho-Pneumonia. (Pre-Operative Risk Grade 1.)

SPINAL CASES—ON TABLE (3)

2 cases of complete obstruction over several days. (Pre-Operative Risk Grade 4.)
1 case of advanced unrecognized general carcinosis with anaemia. (Pre-Operative Risk Grade 3.) (Looked sturdy.)

SPINAL CASES—POST-ANAES. (2)

1 Obstruction and Peritonitis over several days. (Pre-Operative Risk Grade 4.)
1 Bilateral (lower) lobar pneumonia. (Pre-Operative Risk Grade 4.) (Cough on admission.)

PNEUMONIA INCIDENCE RE OPERATIVE FIELD:

Ether cases (2)—All lower abdominal cases.
Spinal cases (1)—Upper abdominal (Cholecystectomy).

(Figure 7)

A Study of Hospital Legislation in Canada

By HARVEY AGNEW, M.D.

ANY discussion of hospital legislation in Canada must be focussed largely upon the general principles of such legislation, for it is obvious that a detailed comparison of the enactments regarding specific points in the various provinces would be, perforce, too extensive for consideration at this time. Moreover, in the evaluation of any legislation it is essential to have a yardstick by which to measure it and, in this particular review one would like to use a three-fold yardstick,—a comparison with other countries, a comparison between our provinces and a consideration of the extent to which our present legislation meets the needs of our hospitals and the public whom they serve.

In many respects hospital legislation in Canada is better than that found in other countries, but many perplexing problems still exist which could be corrected by well directed legislation.

While we know that our present legislation is far from Utopian and can stand much improvement, it must be a source of gratification to both hospital workers and governments to realize that in many respects it is better than that found in other countries. Nobody in this country is ever denied hospitalization because he hasn't the money or doesn't hold a "card." The great majority of our hospitals are "in the red" and some have had to close, but even so our hospitals are not in so serious a plight as they are, say, in the United States, where the great majority of states provide no grants whatsoever.

It is practically impossible to compare our legislation with that on the continent where the health services are so extensively nationalized, but we all know the serious difficulties facing the voluntary hospitals in England, the financial problems of which have not been simplified by the widespread development of the county council or municipal hospitals.

Our federal legislation has been very fair and the government has shown a very favourable attitude in recent years. Certain equipment now has free entry either under the general or the Imperial preference arrangements. It is hoped that this free list will be broadened so as to include baby incubators, hospital dishwashing equipment, forceps, etc. The exemption of hospital purchases from sales tax has been much appreciated by our struggling institutions. Moreover, our hospitals have received very fair consideration with respect to the hospitalization of war veterans, Indians and salt water mariners. Governmental institutions have not been in competition with other hospitals for paying private patronage as in some of the states to the south.

Provincial Enactments

Whether or not the B.N.A. Act requires it to be so, matters of health have been considered to be largely the responsibility of the provinces. All provinces, with the exception of Prince Edward Island, have hospital acts, and the deficiency here is made up by Saskatchewan, whose hospital enactments are scattered through several acts.

In all provinces matters concerning the hospitals are the responsibility of certain Ministers, usually the minister of Health, but in British Columbia, of the Provincial Secretary. Until the Ministry of Health was created in Nova Scotia a few years ago, hospital affairs there were divided between four departments. One province (Ontario) has a Deputy Minister of Hospitals as well as a Deputy Minister of Health.

Grants

As stated above Canadian legislation is featured by provision for provincial and municipal grants. These are made to what are called "public" hospitals, even though many are operated by private voluntary boards. In most of the provinces the *provincial* grant is limited to public ward patients only, while in the three western provinces the provincial grant covers all patients. Payment for all patients may be interpreted as an excellent manifestation that all sick patients need assistance and that the paying patient should not have to bear part of the cost of the free or part pay patient. In two provinces, New Brunswick and Prince Edward Island, the grant is given as a lump sum; in the other provinces the grant is on a per diem basis. This varies; in Nova Scotia it is ridiculously low—thirty cents per diem up to a total of $1,500.00, then twenty cents per diem. Babies are not included. Manitoba is now down to forty cents per diem. Alberta and Saskatchewan pay fifty cents, Ontario pays sixty cents less a variable reduction, and Quebec pays from 35 cents to one dollar depending upon the size of the hospital. Your own reduced grant is only too well known to you. (The B.C. government pays a graded grant for the first 10,000 patient days, following which the grant is now forty-five cents.)

The *municipal* grant for indigent care varies considerably. In Nova Scotia the rate shall not exceed two dollars per diem; in New Brunswick, it shall be the average cost per diem in that hospital; in Quebec the charge is 35 cents, 67 cents or $1.00, depending upon the size of the hospital; in Ontario it is $1.75; in Manitoba the average cost, but not to exceed $1.50; in Saskatchewan $2.50 per diem; in Alberta the public ward rate with a maximum of $200 in any one year. As you know, the British Columbia rate is 70 cents, although in this province it covers all patients while, in the others it applies to admitted resident indigents only.

An address presented at the British Columbia Hospitals Association Convention, Victoria, November, 1933.

The provinces from Ontario to British Columbia provide a grant for babies born in hospitals.

Throughout Canada the mental institutions are considered the responsibility of the provincial governments and communicable disease care that of the municipality. While tuberculosis sanatoria have been strongly aided by governments throughout Canada, consideration of effort and provincial direction has been most manifest upon the prairie, particularly in Saskatchewan.

A full and interesting comparison of various phases of hospital legislation in the different provinces has been made by the Committee on Legislation of the Canadian Hospital Council, copies of which report will soon be available. It is interesting to note in how widely divergent ways our eight provinces handle similar problems. For instance, "residency" is fixed at but thirty days in one province (Sask.), in another at one year (Que.), while in still another (N.S.), "residency" may be established overnight and yet "settlement" takes up to five years. "Indigency" that *bête noir* of both hospitals and municipalities is so difficult to define that Manitoba, Ontario and New Brunswick do not define it in their hospital acts at all!

A study of this comparative analysis reveals also that some of the provinces have more effective legislation on certain points than do others. For instance, in some provinces, indigents may be admitted without authority of the municipality provided urgency is attested by the superintendent or the attending physician. Also, in case of dispute as to the liability of a municipality for payment, one province refers the matter to the inspector of Municipalities (B.C.), others to the Minister (Alberta and Manitoba), while others refer the dispute to a Judge (Quebec and N.B.). In Nova Scotia the clerk of the municipality and the hospital board settle the matter between them.

The right of a municipality to reimbursement for payment of the account of an alleged indigent varies widely. Certain provinces apparently make no provision, while another (N.S.) provides for such reimbursement even from the grandparents and grandchildren. In Saskatchewan, the municipality shall have a charge on the land recoverable as taxes.

There is a tendency now for certain municipalities to go "shopping" for the cheapest care of their indigents this has frequently resulted in certain municipalities refusing to recognize accounts from other hospitals to which some of their residents may have gone. As far as I know, Alberta is the only province to definitely set forth in its Act protection for the non-contract hospital. This province requires a contracting municipality to pay the non-contract hospital its public ward rate or two dollars and fifty cents per diem, whichever is the lesser.

In connection with contracts the medical profession has protested that it is unfair for a hospital making such a bargain to expect its medical staff to add to its already heavy burden of free care without either recompense or even consideration. Recently the executive of the Alberta Hospital Association passed a resolution recommending that hospitals enter into no contract which would require unpaid medical services.

One of the problems facing our hospitals is the care of the indigent transient from another province. With increasing motor travel, particularly that ubiquitous and demoralizing habit, "hitch-hiking," these cases have become more numerous. In the three prairie provinces, the hospital legislation has made provision for the recognition of the accounts of hospitals in other provinces, provided such other provinces pass similar legislation recognizing the accounts of their hospitals. Apparently all that is needed now is reciprocal action to validate the arrangement and already Saskatchewan and Manitoba have come to an agreement with respect to rural municipalities. I understand that British Columbia and Alberta are now considering some such arrangement. This is a laudable development and one which should be agreed to by every province in Canada.

Oversight of Hospitals

It is to be anticipated that, with increasing assistance being given to hospitals by the state, a greater measure of governmental oversight may develop; in fact it is the duty of the government to see that public funds are expended as wisely as possible and the duty of the government to recognize no hospital, public or private, which does not safeguard the interests of its patients in every way possible.

At the present time all provincial governments do exercise some measure of approval over the hospitals and most require approval before aid is given. Some have special inspectors. In Nova Scotia the government appoints one board member in every hospital receiving government aid. In B.C. the government has this right also. However, all too often the supervision of approved public hospitals is limited largely to sanitation and fire protection and a scrutiny of the financial statistics rather than analysis of the professional work.

One gathers that there is a strong sentiment among hospital workers that some form of general oversight or guidance, either voluntary or governmental, should maintain direction over the activities of our hospitals; that perhaps the government, in co-operation with medical and nursing organizations, should require a more careful analysis of the professional work done in hospitals. There are still too many hospitals, particularly smaller ones, whose staff organization or discipline committee, if there be such, is moribund; whose records of work done are not worth the price of the paper on which they are written; which seldom, if ever, make a postmortem check on their diagnosis. Similar observations might be made of certain badly equipped so-called "training schools" for nurses.

There is a feeling also that something might be done to co-ordinate the efforts of our citizens to provide hospital care for their communities. Our hospital programme seems to be such a haphazard one. Here we have a community overhospitalized; there one utterly lacking in hospital facilities. Two or three closely adjacent towns may each have a small badly equipped and staffed hospital whereas one joint hospital could be so much more effective. We see general hospitals with closed private wards and yet nowhere in town accommodation for the incurable, the chronic or the isolation case. We have but 500 convalescent beds in Canada—and four of our provinces have no such facilities whatsoever! Surely it should be possible to tactfully direct a programme of hospital development towards a complete community service with-

(Continued on page 26)

How Hospitals Are Meeting Present-Day Conditions

By MALCOLM T. MacEACHERN, M.D., C.M., D.Sc., F.A.C.P.,
Associate Director, American College of Surgeons, and
Director of Hospital Activities

PART II.

There is still another way in which some hospitals are managing to meet present-day conditions through subsidy of the government. Some communities have contracted with private hospitals for the care of tuberculosis, mental, and infectious diseases. Their own municipal and state institutions greatly overcrowded, these governments find it advisable to send cases to non tax-supported hospitals and subsidize their treatment. On the other hand, the private or community hospitals find this an excellent means by which to fill their vacant beds and absorb their overhead costs. Many hospitals are extending their services to all types of patients so far as their facilities and personnel will permit. Two hospitals in a certain community are caring for all infectious diseases in that community for which the city pays three dollars per day. Such a plan not only fills empty beds; it assures the greater use of already existing facilities; there is no lowering of efficiency; rather, there is an increased service in offering the patient the advantages of a fully organized medical staff, including the various specialties close at hand. At the same time it is a greater saving to the taxpayer.

Various plans of periodic payments for hospitalization are rapidly developing, and better provision being made for the patient of moderate means.

From coast to coast attention is being directed to some form or other of prepayment plans for hospital care. This has been stimulated in a great measure through the Report of the Committee on the Costs of Medical Care. In its findings, the Report stated that it was not the high cost of medical care which was the problem, but the distribution of this cost so as not to place a burden upon any particular individual or group of individuals, particularly the patient of moderate means or low wage earner. You will recall that this report pointed out that on the average, a person spends approximately $30 per annum for medical care, including all kinds of services such as medical, hospital, dental, nursing, drugs, and supplies.

If we could distribute illness on a per capita basis of $30 annually, the problem would be solved, for then, at least all people of moderate means could meet the demand, but as you know, it is the one person out of ten who must carry the major expense of illness. This person, as a rule, cannot meet the cumulative charges no matter how reasonable they may be. Furthermore, no one can prophesy far in advance who will need medical care or the amount of medical care and hospital service that such a person may require in any given year.

We, therefore, face the problem of how to distribute this cost without undue burden. Consequently, many schemes of group hospitalization or prepayment plans for hospital services are now afloat. Many have taken root and appear to be working satisfactorily in different communities. In Canada there has been much discussion concerning health insurance, voluntary and compulsory. There can be no doubt that the principle of health insurance aims at an equitable distribution of the costs of medical care so as to remove the burden from the individual and make it collective. In Canada there is a small number of successful instances where through the payment into a monthly fund or sick benefit of some kind, hospitalization, and sometimes medical care also, has been made available to those who pay, without further charge, but with certain restrictions of service. This principle, regardless of the various names given to it, is being tried out in a number of places in the United States and is more or less universally advocated. It generally goes under the designation of group hospitalization and avoids the characterization of insurance under any manner whatsoever.

So far as a plan of group hospitalization is concerned, it is advisable that it should not restrict the patient to one hospital only. Nor must his choice of physicians in the community be limited to one or a few members of the medical profession. In a plan on a monthly free basis or on any other system the patient should have not only free choice of an approved hospital and a licensed physician, but must not in any way be subject to too many restrictions in the plan of treatment. Any plan which limits the patient to one particular hospital for treatment or one particular group of doctors leads to uneven distribution of services and naturally works financial hardship on other hospitals and members of the medical profession.

It is advisable in any new plan of hospitalization on a group purchasing basis that it be as far as possible divorced from the physician's fee and be endorsed by organized medicine and hospitals. And it should be remembered that the best interests of the patients must always be uppermost in mind in any scheme put forth for the financing of hospitals.

Hospitals are co-operating in the use of facilities and services, and in some instances consolidating institutions.

More and more are hospitals co-operating in their work. More and more is antagonistic competition being broken down. More and more are hospitals recognizing that the only competition should be in quality of service rendered, rather than cut-rates or other supposed attractions.

In some communities, institutions have consolidated so as to reduce overhead expenses. Five years ago in St. Joseph, Missouri, there were three hospitals. To-day there are but two, which are ample to meet the needs. I have in mind, also, two other cities of 250,000 population, each

Editor's Note: The first part of this address appeared in the December issue of the Canadian Hospital.

having nine hospitals, whereas four or five would serve the necessary purposes.

Many institutions have found that co-operation in the use of facilities and services has promoted economy and efficiency. It is expensive to have duplication of departments and of high-priced personnel. Two hospitals in one community who are sharing costly facilities and the services of pathologists, radiologists, and physical therapists, have materially reduced expenses and improved their services.

There is no reason why a good pathologist or radiologist could not distribute his services among two, three, or four hospitals, depending upon the size of the institutions and the technical assistance available. The cost of such a plan is certainly much less than that incurred by each hospital having its own high-priced specialists. Present-day conditions have taught us what a silly notion is the attempt to "keep up with the Joneses." The trend today is co-operation—real and sincere—so as to prevent duplication of services and thereby reduce expenses.

We must encourage at every opportunity the consolidation of effort and the sharing of existing facilities if economy and efficiency are to be maintained. Jealousy, rate-cutting, unfair competition must be abolished.

Hospitals are urging local physicians to utilize hospital facilities and equipment.

The successful practicing physician in good times aimed at making his private office a complete diagnostic centre and occasionally a minor hospital. He installed X-ray, clinical laboratory, and physical therapy equipment, necessitating an increased number of technical personnel. All this has cut down the volume of such work formerly sent to hospitals, and as a result, in the past few years the revenue from these services has shifted from the "black" to the "red." This may have also added to the cost of medical care. In one city of 20,000 people in a western state the investigator of the American College of Surgeons found two well equipped 70--80 bed hospitals, 22 practicing physicians, and 18 X-ray outfits, including the two in the hospitals. There was an investment of more than $80,000 in X-ray equipment in that community, whereas the two departments in the hospitals could have more than served the community needs.

However, these conditions are being remedied. Not only are hospitals co-operating among themselves to prevent duplication of facilities and services; they are offering complete diagnostic and therapeutic facilities to the local medical profession for their private patients at as reasonable a charge as possible.

Physicians who are now utilizing hospital equipment for their office and private patients find that they have cut down their individual overhead tremendously. Not only have they eliminated the necessity of purchasing and maintaining highly expensive equipment, but they have also removed the necessity of having additional personnel.

There is no reason why every physician should not support the hospital of his choice to the fullest extent, not only with regard to patients admitted to the institution, but also in the use of facilities for his office and private patients. The hospital is more and more becoming the workshop of the modern doctor. The support of the physician for the hospital by increasing its business enables

that institution to maintain more high-grade services. In most instances, hospital facilities can be used by the private practitioner with much less expense and frequently with greater facility and efficiency.

Therefore, in the future let us encourage greater centralization rather than decentralization of medical services.

Hospitals are more vigorously promoting convalescent care.

There is a phase in the life of mostly every hospitalized patient which can be designated as a period of convalescense or that period in which the patient has passed the dangers of his illness and starts on the road to recovery. This is a distinct demarcation from the acute stage when the patient is bedridden and practically unable to care for his physical necessities and when rest in bed is essential for the restoration to normal functioning of the organ or that part of the body affected. Convalescent care marks the time when the patient is ambulant or semi-ambulant and able to care for all or mostly all of the physical wants of his body. As such, the environment of the patient requires a change. It is not desirable for the convalescent patient to be in the atmosphere of serious illness, nor is it good for the patient seriously ill to be in contact with the convalescent patient.

For the general good of both types of cases, properly constructed and equipped convalescent hospitals are being promoted in some communities. These are limited in number and not as frequently found as they should be. These institutions are especially planned and equipped for the promotion of rapid convalescence. Such facilities as occupational therapy, physical therapy, libraries, reading rooms, entertainment, and other features are to be found which promote the welfare, happiness, and contentment of the patient—all conducive to more rapid and substantial convalescence. Undoubtedly, a proper system of convalescent care achieved by segregating the patients who need the more costly type of service from those that can be cared for on a lower per diem per capita would save the hospitals many hundreds and thousands of dollars per year; in addition, it would greatly accelerate convalescence, and contribute to the happiness and mental and physical welfare of the patient.

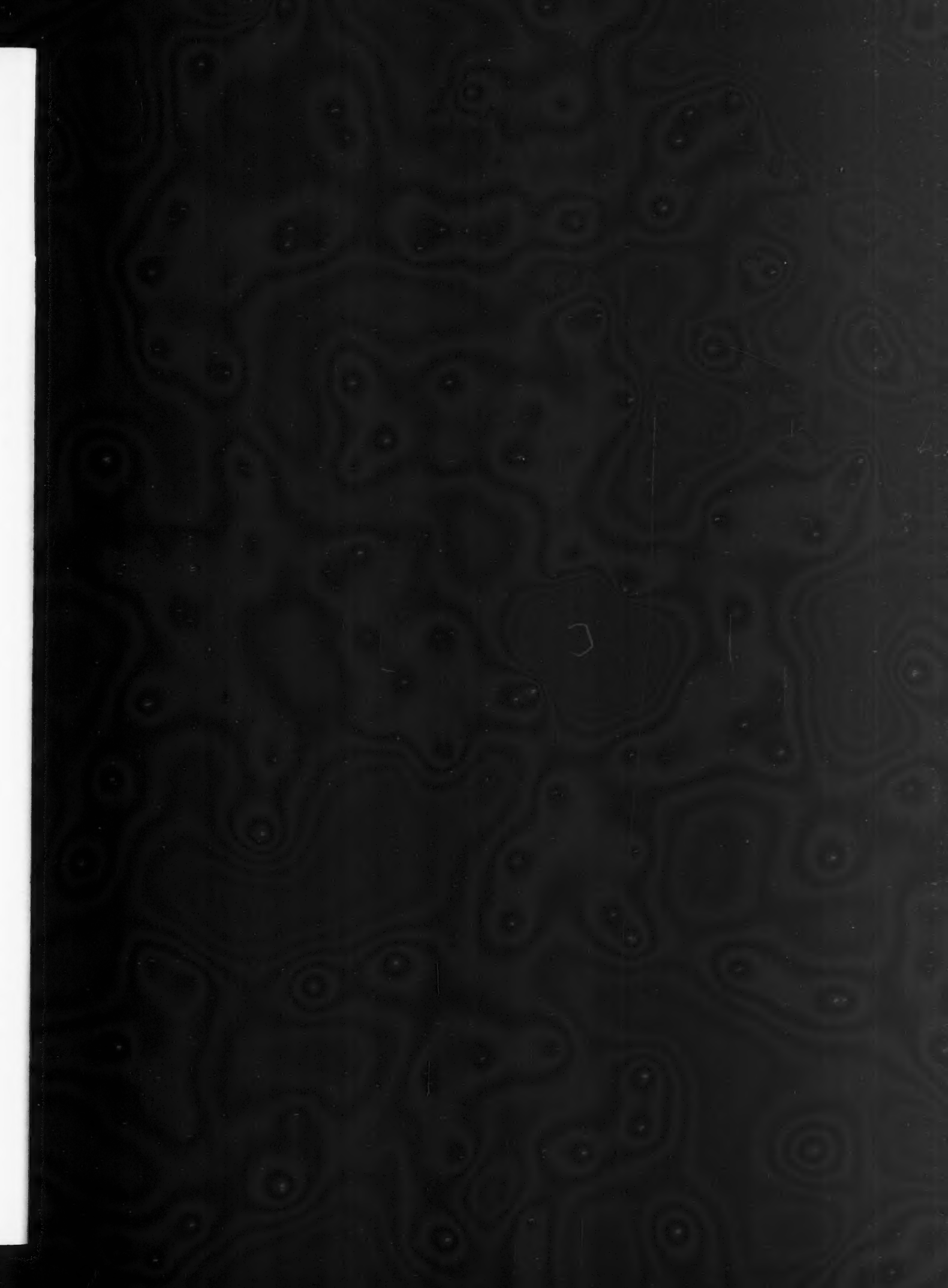
Hospitals are organizing health inventoriums.

There is no question but what added emphasis is being given these days to the prevention of disease. The care of the sick and injured has since time immemorial been considered the duty of the hospital. But that institution has taken on an added function—to prevent disease and promote health—in other words, it has become a health factory. Heretofore, hospitals have dealt largely with terminal conditions. Diseases have usually been evident upon admission, and the task of the hospital has been to ameliorate, mend, or cure.

The health inventorium as organized in approved hospitals to-day is an effective way in which to handle the periodic examination. The public is being urged to have a complete, regular, physical examination at least once each year. The hospital is the ideal place in which to make the examination.

A growing number of institutions are furnishing ex-

(Continued on page 22)



Kalmerid Catgut

EMBODIES all the essentials of the perfect suture. Being impregnated with the double iodine compound, potassium-mercuric-iodide, it exerts a bactericidal action in the suture tract and supersedes the older unstable iodized catgut. Prepared in two varieties—Non-Boilable for those desiring the maximum of suture flexibility, and Boilable for those preferring to sterilize the exterior of tubes by boiling or autoclaving. Both varieties are heat sterilized.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH
1405	PLAIN CATGUT	*approx.* 5′
1425	10-DAY CHROMIC	" 5′
1445	20-DAY CHROMIC	" 5′
1485	40-DAY CHROMIC	" 5′

BOILABLE VARIETY

1205	PLAIN CATGUT	*approx.* 5′
1225	10-DAY CHROMIC	" 5′
1245	20-DAY CHROMIC	" 5′
1285	40-DAY CHROMIC	" 5′

Sizes: 000..00..0..1..2..3..4
also 4-0 in non-boilable variety

Package of 12 tubes of a kind.....$3.60

Kal-dermic Skin Sutures

A NON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.

NO.		SUTURE LENGTH	DOZEN
550	WITHOUT NEEDLE	120″	$3.60
954	WITH ½-CURVED NEEDLE	20″	3.00

Sizes: 000 (FINE) 00 (MEDIUM) 0 (COARSE)

852	WITHOUT NEEDLE	40″		1.80

Sizes: 8-0..6-0..4-0..000..00..0

In packages of 12 tubes of a kind and size

Kal-dermic Tension Sutures

IDENTICAL in all respects to Kal-dermic skin sutures but larger in size.

NO.		SUTURE LENGTH	DOZEN
555	WITHOUT NEEDLE	60″	$3.60
855	WITHOUT NEEDLE	20″	1.80

Sizes: 1 (FINE) 2 (MEDIUM) 3 (COARSE)

In packages of 12 tubes of a kind and size

Intestinal Sutures

KALMERID plain or chromic catgut with Atraumatic needles integrally affixed. For gastro-intestinal work and membranes where minimized trauma is desired.

EXCEPTIONAL STRENGTH HERE

NON-BOILABLE VARIETY

Plain Catgut:

NO.		SUTURE LENGTH	DOZEN
1501	STRAIGHT NEEDLE	28″	$3.60
1503	⅜-CIRCLE NEEDLE	28″	4.20
1504	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1505	½-CIRCLE NEEDLE	28″	4.20

20-Day Chromic:

1541	STRAIGHT NEEDLE	28″	$3.60
1542	TWO STRAIGHT NEEDLES	36″	4.20
1543	⅜-CIRCLE NEEDLE	28″	4.20
1544	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1545	½-CIRCLE NEEDLE	28″	4.20

BOILABLE VARIETY

Plain Catgut:

1301	STRAIGHT NEEDLE	28″	$3.60
1303	⅜-CIRCLE NEEDLE	28″	4.20
1304	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1305	½-CIRCLE NEEDLE	28″	4.20

20-Day Chromic:

1341	STRAIGHT NEEDLE	28″	$3.60
1342	TWO STRAIGHT NEEDLES	36″	4.20
1343	⅜-CIRCLE NEEDLE	28″	4.20
1344	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1345	½-CIRCLE NEEDLE	28″	4.20

Sizes: 00..0..1, except *00..0 only

In packages of 12 tubes of a kind and size

Circumcision Sutures

KALMERID plain catgut threaded on a small, full-curved eyed needle, or with an Atraumatic needle integrally affixed.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
630	WITH EYED NEEDLE	28″	00, 0
635	WITH ATRAUMATIC NEEDLE	28″	00, 0

BOILABLE VARIETY

600	WITH EYED NEEDLE	28″	00, 0
605	WITH ATRAUMATIC NEEDLE	28″	00, 0

Package of 4 tubes $1.20; per doz. $3.60

DISCOUNTS ON QUANTITIES

Obstetrical Sutures

KALMERID 40-day catgut threaded on a large, full-curved eyed needle, or with an Atraumatic needle integrally affixed.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
680	With Eyed Needle	28″	2, 3
685	With Atraumatic Needle	28″	2, 3

BOILABLE VARIETY

650	With Eyed Needle	28″	2, 3
655	With Atraumatic Needle	28″	2, 3

Package of 3 tubes $1.20; per doz. $4.20

Special Purpose Sutures

WITH Atraumatic needles integrally affixed. Selection of needles and material based on consensus of professional opinion. Suture length 18 inches. Boilable.

Plastic Sutures:

NO.	MATERIAL	SIZE	NEEDLE SHAPE	LENGTH
1651	Kal-dermic	6-0	3/8-Circle	3/8″
1655	Kal-dermic	4-0	1/2-Curved	7/8″
1658	Black Silk	4-0	1/2-Curved	7/8″

Eye Sutures:

1661	Black Silk	6-0	1/2-Circle	3/4″
1665	Black Silk	4-0	3/8-Circle	3/8″
1666	Plain Catgut	3-0	3/8-Circle*	1/2″
1667	Plain Catgut	3-0	3/8-Circle	1/2″
1668	10-Day Catgut	3-0	3/8-Circle*	3/8″
1669	10-Day Catgut	3-0	3/8-Circle	5/8″

* Double armed, suture length 12 inches

Nerve Sutures:

1670	Black Silk	6-0	Straight	3/8″

Artery Sutures:

1675	Black Silk	6-0	Straight	3/4″
1678	Black Silk	6-0	1/2-Circle	3/4″

Package of 12 tubes of a kind $4.20

Tonsil Sutures

KALMERID plain catgut with a 1¼ inch half-circle Atraumatic needle of correct diameter affixed. Suture length 28 inches.

NO.		SIZE
1605	Boilable Variety	0
1615	Non-Boilable Variety	0

Package of 12 tubes $4.20

Ribbon Gut

AN absorbable ribbon of animal intestinal tissue for nephrotomy wound closure by the Lowsley-Bishop technic. Ribbon length, 18 inches. Boilable.

NO.		WIDTH
20	Plain	5/8″

Package of 12 tubes $3.60

Short Sutures for Minor Surgery

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
702	Plain Kalmerid Catgut	20″	00 to 3
722	20-Day Kalmerid "	20″	00 to 3
742	40-Day Kalmerid "	20″	00 to 3

BOILABLE VARIETY

802	Plain Kalmerid Catgut	20″	00 to 3
812	10-Day Kalmerid "	20″	00 to 3
822	20-Day Kalmerid "	20″	00 to 3
842	40-Day Kalmerid "	20″	00 to 3
862	Horsehair	56″	00
872	White Silkworm Gut	28″	0
882	White Twisted Silk	20″	000, 0, 2
892	Umbilical Tape	24″	1/8″ wide

Package of 12 tubes of a kind $1.80

Emergency Sutures

THREADED on half-curved eyed needles with cutting edges for skin, muscle, or tendon. Boilable.

NO.		SUTURE LENGTH	SIZES
904	Plain Kalmerid Catgut	20″	00 to 3
914	10-Day Kalmerid "	20″	00 to 3
924	20-Day Kalmerid "	20″	00 to 3
964	Horsehair	56″	00
974	White Silkworm Gut	28″	0
984	White Twisted Silk	20″	000, 0, 2

In packages of 12 tubes of a kind

Emergency Suture Assortment:

900 . . Assorted—Catgut, Silk, and Kal-dermic Skin Sutures, on half-curved needles

Package of 12 tubes $3.00

Other D&G Products

INFORMATION and prices covering silk, kangaroo tendons, horsehair, celluloid-linen, umbilical tape in jars, and Kalmerid germicidal tablets will be sent upon request.

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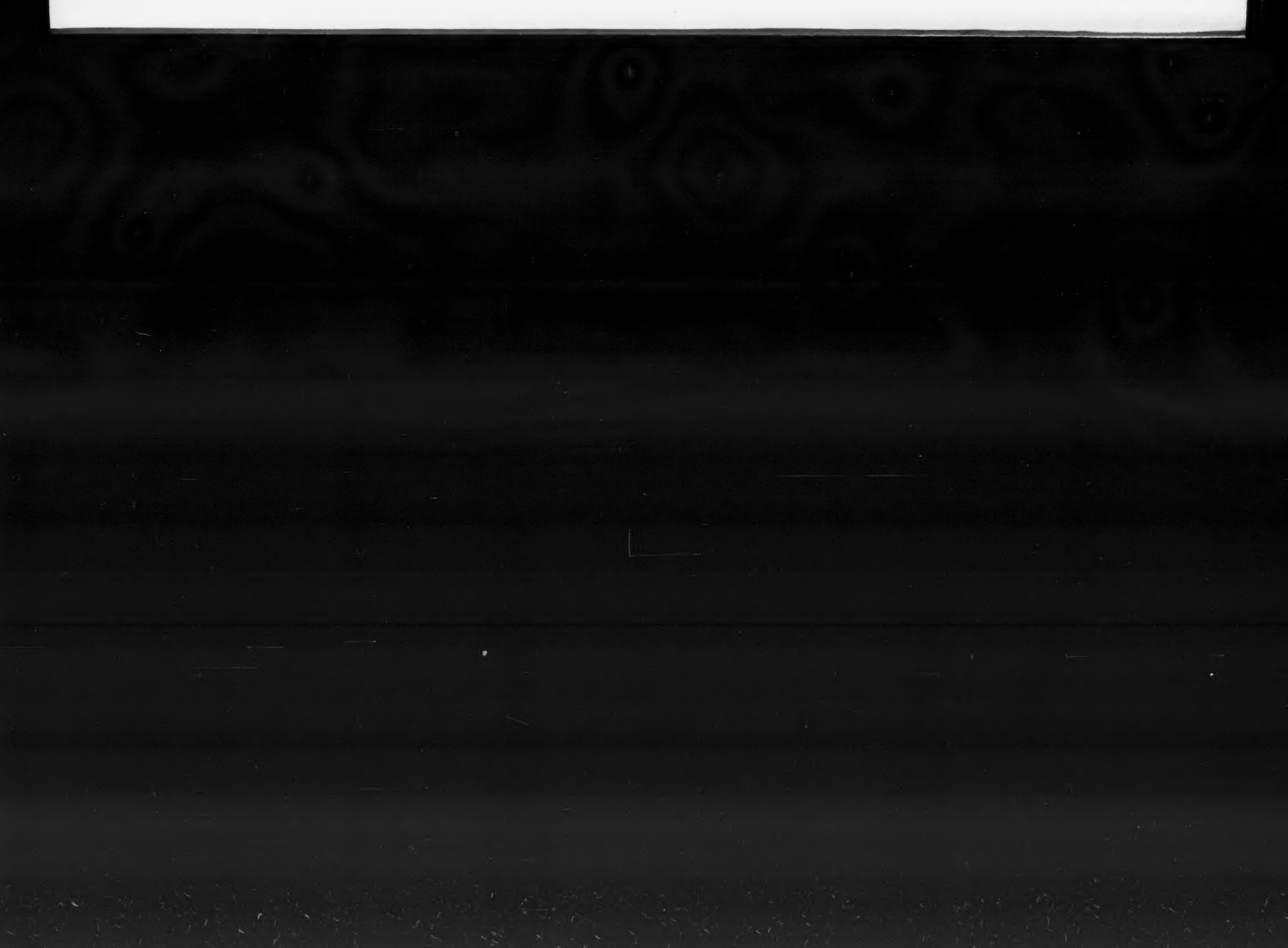
SUTURES IN ANCIENT SURGERY

HEINRICH von PFOLSPEUNDT was a knight of the Teutonic Order and his experience in wound surgery was gained during the wars with Poland. His was the first surgical treatise written in German (1460), was the first to describe gun-shot wounds, and shows an insistance on cleanliness far in advance of his time He used sutures sparingly in the treatment of wounds but when necessary inserted a few interrupted sutures of green silk passed deeply through the tissues and tied over a quill or silver tube.



St. John's Convalescent Hospital is Assured, Says Mr. Massey

With 40 per cent. of the workers yet to report on December 16th, more than $100,000 had been subscribed in the campaign for the new St. John's Convalescent Hospital, the total objective of which is $300,000. The women's special names' committee was within $4,000 of its objective of $25,000, it was stated.

Among the large subscriptions are the following: The Massey Foundation, $25,000; Gerald R. Larkin, $10,000; T. Eaton Co., Ltd., $5,000; Sir Frank Baillie Memorial Fund, per lady Baillie, $2,500; Canada Packers, Ltd., $2,500; Robert Simpson Co., Ltd., $2,500; Elias Rogers Co., Ltd., Clarence A. Bogert, Lady Eaton, G. Harrison Smith, Imperial Oil Ltd., Wm. Wrigley Jr., Co., Ltd., Mrs. Lionel H. Clarke, the Misses Brock, Miss Helen F. Grand, and Mrs. R. J. Christie, each $1,000.

"We now know that the St. John's new convalescent hospital is assured," said Mr. Vincent Massey. "Our faith in the project is already justified. With the money received and what we are sure of receiving, the new building is a certainty and from now on added subscriptions will only mean a larger number of beds for the hospital."

Mr. Massey, general campaign manager, declared that every effort will be made to bring the total up to the $300,000 objective "and, if possible beyond it."

Dr. F. Cleland, Noted Surgeon Dies Suddenly

Dr. Frederick A. Cleland, 6 Warren Road, Toronto, gynaecologist and abdominal surgeon, died suddenly on November 26th, at his home, from a heart attack, in his 60th year. He had appeared to be in good health on the Saturday previous, performing a major operation at the hospital.

A son of the late James Cleland, former M.P.P. for North Grey, he was born at Meaford. He was educated there, and at the University of Toronto, graduating in 1901, and took post graduate work in Europe. He was known throughout Canada as a leader in abdominal surgery.

He gave freely of his time and talent in public medical life, having been in charge of services successively in St. Michael's Hospital and Grace Hospital, and later on the staff of the Toronto General Hospital. He also did much work in St. John's Hospital.

He was a past president of the Academy of Medicine at Toronto, a charter Fellow of the American College of Surgeons and a past vice-president of the American Association of Gynaecologists, Obstetricians and Abdominal Surgeons.

During the Great War he served with the C.E.F. in Siberia as senior surgeon.

He was a member of Westminster-Central United Church, the York Club and Toronto Hunt Club.

Surviving are his wife, formerly Miss Anna Goldie, of Ayr; two daughters, Isabel and Esther; two sons, James and Hugh, Toronto; four brothers, Lt.-Col. Hugh R. and Edward S. Cleland, Meaford, and James H. and Donald M. Cleland, Toronto.

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Should Drugless Practitioners Be Admitted to Our Hospitals?

FAILURE on the part of a drugless practitioner to conform with the provisions of the health regulations brought his censure by a jury which recently investigated the death of a young girl from the effects of diphtheria, in one of our large cities.

According to the press, upon investigation this man admitted he diagnosed the case as "tonsilitis, diphtheria or infantile paralysis," yet his only treatment was to prescribe a fruit diet and to give an "adjustment."

Apparently this drugless practitioner admitted that he did not report the case to the proper authorities, take a swab nor administer anti-toxin, despite the overwhelming scientific and statistical evidence of the value of such procedures.

This case is of interest to hospital workers in view of the repeated efforts of the osteopaths to gain admission to hospitals. Frequently it is a request to utilize the radiological or the pathological laboratories; they have requested the right to treat compensation cases and in fact, to treat all types of cases.

While the strength of the various irregular cults seem to be definitely waning in Canada, the demands for hospital and other privileges are increasing, and any success in one province is likely to result in increased demands in other provinces.

Without doubt beneficial result has followed in many instances from the practice of manipulation in the hands of both the medical profession and the drugless practitioners. Hospital workers are fully aware of the excellent results which may be obtained by the use of physiotherapy in proper hands and scientific dietetic supervision. These aids have proven most helpful in the treatment of disease, but all too frequently the credit has been given to an unscientific theory of the causation of disease. The disastrous results which have followed erroneous diagnoses or injudicious manipulation or electric therapy are only too well known.

Contrary to popular belief, the medical profession, we understand, does not oppose the practice of manipulative surgery, massage nor physiotherapy, as is so frequently claimed by cultists; in fact these are practiced quite extensively by medical men and are taught in the medical colleges. The medical profession in Canada has steadily maintained that there should be but one portal of entry to the healing profession. It is in the interests of the public that every practitioner licensed to treat the sick should be thoroughly grounded in the basic medical sciences, and have had a thorough clinical training, a wide post mortem and pathological experience, and an intimate knowledge of all of the diagnostic and therapeutic procedures which modern science has developed.

Adequate Training is Essential

If an individual, having taken such a training, desires to practice a special and restricted field of medicine, call it what he will, the medical profession apparently has no objection to such procedure, knowing that his training in the fundamentals should be a measure of protection to the public, but the profession would seem to be rightly consistent that there should be no back door entry through ill equipped or directed institutions of training.

Incidentally any hospital admitting other than regularly qualified medical practitioners to its staff would lose its standardization grading with the American College of Surgeons, and moreover, could not be approved for internship. Apparently hospitals in England are facing similar demands judging from press publicity, and it is interesting to note the following excerpt from the pen of the celebrated Lord Moynihan, one of the greatest surgeons of this generation:—

"The lay mind seems to find it unaccountably difficult to understand the professional attitude towards the unorthodox practitioner. We accept the view of Bacon that 'The weakness and credulity of men is such as they will often prefer a mountebank or a witch to a physician.' We do not deny to such a practitioner the possession of a degree of competence in manipulative methods; we do not doubt either his sincere devotion to his task of his personal integrity, nor do we disparage the irresponsible gay confidence he shows in his own very limited powers. We do not grudge him success though we recognize its infrequency, and are not unfamiliar with its perilous accompaniments, its fatal disasters. Our opposition rests on something more fundamental than this: upon his complete lack of adequate training in the most elementary principles which underlie all powers of diagnosis, and in appropriate application of those principles in directing treatment. Such principles are not empirical; they are based upon a multitude of sciences, upon physiology, anatomy, bacteriology, pathology, bio-chemistry, radiology and the like, and upon that trained clinical observation which seeks to determine not only the morbid local condition but also its correlation of the patient."

1934 Revision of Internship List is Available

THE 1934 revision of approved and recommended hospitals has just been issued by the Department of Hospital Service of the Canadian Medical Association, and copies may be obtained by writing to Doctor Harvey Agnew, at 184 College Street, Toronto.

This list contains the names of 33 "approved" hospitals offering 459 desirable internships and 15 "recommended" hospitals providing 92 internships, an increase in all of 69 internships over last year. This is particularly gratifying in view of the fact that recent graduates are finding it more difficult to take their post-graduate studies in the United States.

A study of the revised list of approved hospitals reveals three hospitals which were not included in the 1933 issue; another hospital showed so much improvement during the past year that it was transferred from the "recommended" to the "approved" listing.

Not only have the interns benefitted from the varied and sound clinical training obtained in these hospitals, but the hospital staffs have been stimulated to better scientific work by the presence of the intern.

As the autopsy percentage is a fair gauge of the scientific spirit of the hospital it is interesting to note that this feature has shown a decided increase during the past two years, one hospital raising its percentage from 15% to 42.5% in one year.

Senior internships and residencies in specialties are listed in a separate bulletin issued by the Department of Hospital Service.

Replacement of Equipment is Problem of Many Hospitals

AT this time of year, if they have not already done so, hospital administrators and boards are looking anxiously ahead as they prepare the year's budget, trying to estimate what may be anticipated as the likely balance between revenue and expenditures. For the last few years hospitals have been reducing their equipment purchases to a minimum; even repairs have been put off to the extent where further delay would prove decidedly unsound.

Many hospital administrators are wondering if now is the time to buy much needed equipment. For several years there has been a definite reduction in the costs of many pieces of equipment, but it has been noticeable that the cost of many commodities has tended to show an upward swing during the last few months. Indications are that in many fields at least this upward swing will be continued during this year. Building costs seem to be rising slowly but definitely, although they are still far below what they were three or four years ago. The gigantic experiment of our neighbours to the south, in their efforts to restore trade has resulted in a rise of equipment cost and experience has taught us to anticipate a reaction in Canada to any such major movements in the United States. In view of this trend it would seem the part of wisdom for hospital administrators and purchasing agents to consider very carefully their anticipated equipment purchases for the current year and make careful investigation as to whether or not they would be warranted in making such purchases at the present time.

News of Hospitals and Staffs

A Condensed Monthly Summary of Hospital Activities, and Personal News of Hospital Workers

CALGARY, ALTA.—Henry Allison Perley, retired, who died October 19, 1933, willed $146,904.44 to Calgary hospital board, it was learned, when application for probate of the will was made in November.

* * *

COBOURG, ONT.—A promise made several years ago by the late John Polkinhan that he would remember Cobourg General Hospital in his will, has been fulfilled. When he died he stipulated that $10,000 was to go to the hospital upon the death of his wife. Mrs. Polkinhan died on November 28th, in Ottawa, where she and her husband had been living.

* * *

EDMONTON, ALTA.—Members of the provincial government, city officials and officers of the St. John Ambulance Association gathered at a luncheon at the Macdonald Hotel on November 25th, given in honour of the visit of Sir J. Hewett, C.G.I.C., Bailiff of the Eagle, of the Ancient Order of St. John of Jerusalem.

The chair was taken by Dr. E. A. Braithwaite, chairman of the provincial council.

The provincial government was represented by the Hon. R. G. Reid, and the city by Mayor Knott. Others present included Dr. R. C. Wallace, president of the University of Alberta, Alex. Ross, chairman of the Workmen's Compensation Board.

* * *

HALIFAX, N.S.—Miss Edith S. Davidson, R.N., has joined the nursing staff of the Ottawa Civic Hospital, of which she is a graduate. After her graduation Miss Davidson took a post-graduate course at the Neurological Institute in New York.

* * *

HAMILTON, ONT.—The $20,000 addition to the laundry at the Mountain Sanatorium has been completed.

The addition, located to the north of the present laundry building, was made necessary by reason of the increased number of patients at the institution, owing to the additional accommodation of the Evel Pavilion. It is three storeys in height and is of brick, the same material used for the original building.

In the basement, accommodation is provided for guinea-pigs, kept by the hospital for experimentation in the laboratories, while the addition to the laundry itself is contained in the second floor. On the third storey, sleeping accommodation will be supplied for the staff.

* * *

LONDON, ONT.—Middlesex County Council on December 7th signed an agreement with the London Hospital Trust setting a rate of $1.85 a day at Victoria Hospital for indigent patients from the county. This rate is 15 cents a day lower than in the past and will save the county between $1,000 and $1,500 a year.

At the same time it was announced that an agreement had been signed with the officials of the Strathroy General Hospital setting the rate at that institution at $1.65 a day for indigents.

* * *

MONTREAL, QUE.—Only 33 years of age and a professor at McGill University here for the past six years, Dr. John Beattie, M.D., D.Sc., associate professor of anotomy at McGill, has left Montreal for England, where he will succeed Sir Arthur Keith, famous British scientist, as conservator of the Hunterian Museum and as director of the Royal College of Surgeons, London. Dr. Beattie will also have charge of the Buxton Browne research farm at Downe, Kent.

* * *

OTTAWA, ONT.—Dr. Albert Charlebois, prominent Ottawa medical man and specialist of children's diseases, died here on November 20th. His passing has saddened a host of friends in the Capital.

* * *

PORT ALBERNI, B.C.—At the regular November meeting of the board of directors of the West Coast Hospital, Mrs. M. V. Duncan was appointed to assume the position of matron to fill the vacancy caused by the resignation of Miss Charlotte McKenzie. Mrs. Duncan, who is a graduate of Royal Alexandra Hospital, Edmonton, was selected from a list of six applicants and her duties commenced on December 1. Her qualifications include that of surgical supervisor of St. Mary's Hospital, Long Beach, California. Mrs. Duncan comes from Vancouver General Hospital, where she was engaged on post-graduate work.

* * *

REGINA, SASK.—Miss R. Rossie, daughter of Mr. and Mrs. E. C. Rossie, Regina, has been appointed laboratory technician at the Welland County Hospital, Welland, Ontario. The creation of this position is the last step toward standardization of the county hospital.

Miss Rossie, who received her high school education at Central Collegiate, graduated from the Hospital for Sick Children, Toronto, in the spring of 1932. She then studied at Grace Hospital, Detroit, where she received her L.T.

Since returning to Regina Miss Rossie has been continuing her work at the laboratory in the Regina General Hospital. She expects the position to open shortly after the new year.

* * *

TORONTO, ONT.—Miss E. R. Graham, of Toronto, for two years public health nurse for Vaughan township, has

been appointed public health nurse for the town of Bowmanville. Miss Graham is a graduate of Toronto General Hospital and of the University of Toronto.

* * *

TORONTO, ONT.—An appropriation of $50,000 to pay for treatment for indigent out-patients was authorized by the Board of Control on November 22nd, on the recommendation of Dr. Gordon P. Jackson, M.O.H.

Dr. Jackson explained the $100,000 provided in the estimates was exhausted at the end of August.

* * *

TORONTO, ONT.—Final building permits have been issued for the extensive work of alterations and additions to the buildings of the Hospital for Incurables. Complete plans and revised application for permit were submitted to the Department of Buildings and the permit that has been issued covers all work planned or at present in progress. Cost of the undertaking is estimated at $42,000.

* * *

TORONTO, ONT.—Mrs. C. A. McRae has been appointed head of the occupational therapy department in the Astley-Ainsley Institution, Edinburgh, Scotland. Mrs. McRae (nee Mabel McNeill) has been at the East General Hospital for three years directing the occupational therapy department, which she established. She is a scholarship graduate of the University of Toronto and post-graduate of the General Hospital.

* * *

TORONTO, ONT.—Officers and chairmen of committees of the Women's College Hospital, elected at the November meeting of the Board of Governors: President, Mrs. A. M. Huestis; Vice-Presidents, Mrs. R. H. Cameron and Mrs. Russell McCormick; Treasurer, Mrs. N. J. Lander; Secretary, Miss Mabel Stoakley. Committee Chairmen—Building, Col. E. C. Goldie; Finance, Mr. N. J. Lander; House, Mrs. R. M. Simpson; Training School, Mrs. Russell McCormick.

* * *

TORONTO, ONT.—Mark Irish, chairman of the Board of Governors of the Toronto General Hospital, announced on December 6th that the Salada Tea Company had made a generous and substantial gift to the hospital recently, in memory of its late president, Hon. P. C. Larkin.

The amount given to the General Hospital was said to be in the neighbourhood of $100,000. The hospital, it was stated, had not yet decided on the character of the memorial.

* * *

TORONTO, ONT.—Miss Marion Kennedy has been appointed supervisor of the Mothercraft Centre, 84 Wellesley Street, Toronto, and has taken over the duties formerly attended to by Miss Jane Carmichael, who is returning to New Zealand. Miss Kennedy, a daughter of the Hon. T. L. Kennedy, is a graduate of the Hospital for Sick Children, and took her Truby King training at Cromwell House, London, England. For the last year she has been doing district and hospital work with the society, and is the first Canadian nurse to be appointed supervisor of the hospital, although other Canadian graduates are employed in district work.

How Hospitals Are Meeting Present-Day Conditions

(Continued from page 12)

amining rooms to any legalized practitioner who is a member in good standing of organized medicine. Providing a health inventorium means that the hospital furnishes every facility in the way of attendants, consultants, and such diagnostic aids as laboratory, X-ray, and electrocardiograph, so as to assure a comprehensive health audit. Usually, no charge is made for the examining rooms, and the charge for laboratory, X-ray, electrocardiagraph, metabolism test, or other diagnostic examinations is made at actual cost.

More and more hospitals are realizing that the prevention of disease is one of the outstanding features in the progress of medicine. They are meeting present-day conditions by providing health inventoriums for periodic health examinations. Moreover, through the health inventorium the hospital has an opportunity to extend its services to the community and play a leading role in educating the public concerning the value of preventive medicine. By opening its doors to all persons who wish to keep well the hospital encourages many to come for treatment who otherwise might neglect needed medical care. The hospital can obtain the support of the entire local medical profession by permitting all ethical physicians the use of the health inventorium, and oftentimes may add to its medical staff desirable physicians who but for the contact achieved through the health inventorium might never have shown an interest in the hospital. To the public the health inventorium spells freedom from pain and suffering, and a longer, healthier lease of life. The annual periodic examination is the surest means of discovering many cases of incipient disease in time to permit a cure. In this way are degenerative diseases warded off, freedom from suffering made possible, and human life prolonged. This is a noble task for any hospital to participate in and provides a further opportunity to serve humanity.

More hospitals to-day than ever before are meeting the standards advocated by national organizations.

Just recently the American College of Surgeons issued a report on 3,555 hospitals of Canada and the United States, of which 2,150 or 67 per cent have been accepted on the Approved List announced on October 9. Of these, 176 excellent institutions are in Canada. These institutions have been declared as meeting the minimum requirements for approval which assure safe and efficient care of the patient. And right here I must pay tribute to the number of hospitals in Canada which are approved by the hospital department of the Canadian Medical Association for intern training. No more magnificent work has ever been done than what our own Harvey Agnew is doing for hospitals and the training of young physicians throughout Canada. These national organizations are accrediting hospitals from the standpoint of increasing efficiency and making those institutions what we want them to be—that is, capable of assuring every man, woman, or child who enters therein safe and efficient treatment.

You are all familiar with the Hospital Standardization Movement of the American College of Surgeons, which your speaker has had the privilege to direct for the past eleven years. Many of you may not be as interested in this movement as are the public. Perhaps, they better realize what it means to them personally. The public's interest is best manifested when I tell you that ten or eleven years ago in this work we might receive fifty to one hundred inquiries each year as to which hospitals were approved. During the past two weeks the number of requests for this information from the lay public which have come to my office has been fifty to one hundred per day, and there is every reason to believe that such inquiries will continue to increase.

What does this signify? It indicates that the public are desirous of knowing which hospitals are safe, honest, and efficient. They no longer want the boarding house or rooming house type of hospital. They want the institution with efficient organization, good medical and nursing services, adequate equipment, and all the rest of the intricate and complicated features which go to make up what they consider good care when sick or injured.

The day has arrived when the public are demanding such information, and you must provide it for them. The fact that a hospital has obtained a state or provincial license is not sufficient unless that state or provincial license carries with it more than mere compliance with underwriters' and sanitary regulations. Such licensing of hospitals will only have effectiveness and protection when it embodies the ten cardinal principles of hospital organization and administration which are as follows:

1. A modern physical plant, properly equipped for the comfort and scientific care of the patient.
2. Clearly stated constitution, by-laws, rules and regulations setting forth organization, duties, responsibilities, and relations.
3. A carefully selected governing body having complete and supreme authority for the management of the institution.
4. A competent, well trained executive officer or superintendent with authority and responsibility to carry out the policies of the institution as authorized by the governing body.
5. An adequate number of efficient personnel, properly organized and under competent supervision.
6. An organized medical staff of ethical, competent physicians for the carrying out of the professional policies of the hospital, subject to the approval of the governing body.
7. Adequate diagnostic and therapeutic facilities with efficient technical service under competent medical supervision.
8. Accurate and complete clinical records filed in an accessible manner so as to be available for study, reference, follow-up, and research.
9. Group conferences of the administrative staff and of the medical staff to review regularly and thoroughly their respective activities in order to keep the service and the scientific work on the highest plane of efficiency.
10. A humanitarian spirit in which the best care of the patient is always the primary consideration.

Commendable progress is being made in the care of the patient despite economic conditions, and hospitals are daily improving their role as life-saving stations to their respective communities. In general, they are choosing their medical staffs with more discriminating care; they are

condemning the practice of fee-splitting; they are holding staff meetings more regularly; keeping more complete and accurate clinical records; maintaining diagnostic and therapeutic facilities under more competent supervision. They are seeing to it that their institutions are living up to standards which will make them better able to meet present-day conditions. They are inculcating in their communities a more genuine respect and sympathy for their institutions.

And, now, you will ask what this has to do with economics which seems to be the central theme of this discussion. The answer is self evident. The saving of human lives, the shortening of periods of illnesses, the alleviation of suffering, pain, misery, and distress, the proper training of physicians, nurses, and other community workers, the education of the public indirectly and en masse to better ways of living, and many other by-products of the hospital's role in the community adds immensely to the economic status of the nation, much more than any statistician or actuary could possibly calculate. And this economic advantage to the nation and to the individual can come only through well organized and properly functioning hospitals of the type worthy of approval.

Hospitals are instilling in the public a spirit of "hospital-mindedness" by evidencing among themselves a growing spirit of "community consciousness."

It has been mentioned several times before that the hospital's first and foremost duty is giving safe and adequate care to its patients. But, to-day, it has another responsibility, and that is—to play a vital part in community life. The day of hospital isolation and mystery is long past. To-day the hospital stands as an integral part in communal life. Not only has the hospital gone into the field of education and research, acting as a training ground for physicians, nurses, dietitians, and others; it has also developed a close relationship with the community. To be recognized by its community, the hospital must take an interest in civic activities and become associated with community advancement and progress. Every contact the hospital makes provides an opportunity to present its case, and emphasize the truly important role it plays in the life of its community.

Such a spirit of "community consciousness" will help the public to become "hospital-minded." It will show the public that the hospital is worthy of playing a major role in the life of the community, that it is a life-saving station, an indispensable servant of the public. But the public must first understand hospitals before they can give their sympathy. They must receive information concerning hospitals, medical service, and nursing care. Unfortunately, many people have been misled through magazine and press articles written by uniformed writers, both lay and professional. It is possible, of course, that some of these writers are inspired more by the compensatory factor than by the desire to inform the public by telling the truth.

But, on the other hand, there have been many splendid articles which have appeared recently in magazines of general interest. Then again, the work of the Public Relations Committee of the American Hospital Association is aimed directly at the problem of educating the public. It has been exceedingly gratifying to see so many hos-

pitals take up the cause in an earnest endeavor to share with the public information concerning hospital services.

But the written word is not the only means of making a community hospital-minded. The spoken word provides a most effective medium of communication with the public. Here every hospital worker has the opportunity to be of service—the superintendent, the medical staff, nurses, interns, dietitians, and all the rest. Here, too, can the women's auxiliary or aid be of real importance. Each member should assume the role of educator so as to inform the public as to the value of hospitals, their services to the community, and the important part they play in the fight of science against disease. The public should be impressed with the importance of preventive medicine; more than that, they should understand what their hospitals are doing along that line for them, and how much they themselves can benefit by taking advantage of the services offered them by their hospitals.

Public relations are becoming increasingly important. The hospital has widened its sphere of influence—and it must continue to do so. It must increase its number of contacts with the community so that it may be looked upon as an inherent phase of communal life. If hospitals are to meet present-day conditions and meet them satisfactorily, the public must become hospital conscious. The services of the hospital must be understood—and going a step further—they must be appreciated. When that situation occurs—and is perpetuated—hospitals will meet all conditions, present and future.

Municipal Hospitals Association Headed by Mr. J. Taylor

At the annual convention of the Alberta Municipal Hospitals Association, which was held during the week of November 27th in Edmonton, Mr. J. Taylor, of Hanna, the retiring president of that body, was re-elected for his second term. Mr. N. McClelland was made vice-president.

Thirteen of the 22 hospitals, members of the association, were represented, and addresses were heard from Dr. M. R. Bow, provincial deputy minister of health; W. B. Milne, supervisor of hospitals; Frank H. Holmes, president of Alberta Association of Municipal Districts.

The municipal hospitals will be used to implement the plan of "state medicine," now being investigated by the provincial government, Mr. Pattinson told the convention in an address on "State Medicine." Mr. Pattinson dealt with the commencement and growth of the idea up to the present report of the commission.

Mr. Holmes expressed the opinion that the Dominion Government should undertake a greater share in the matter of hospital service for indigents and spoke at some length on indigent accounts to hospitals.

Mr. Milne dealt with the new legislation incorporated in the Municipal Hospitals Act, including three important resolutions at the last convention.

Eight resolutions were passed with one of the most important asking that the government amend the act to allow hospital boards to impose penalties on councils where they are in default of appropriations.

A resolution gave full endorsation to the proposed system of "state medicine."

Provision Should Be Made for More Women Interns

THERE is a noticeable lack of internship facilities in Canada for the young women graduating in medicine, and this has become more apparent since openings in the United States are so much more difficult to obtain.

Practically half of the hospitals on the "Approved" and "Recommended" list of the Department of Hospital Service of the Canadian Medical Association do not accept women interns; their objection would seem to be due mainly to the difficulty of furnishing suitable accommodation. Housemen usually have their quarters in an upper wing or building adjacent to the hospital and it is difficult to make special provision for the women. The practical difficulty has been that most hospitals have been utilizing every square foot of floor space in the hospital, and in almost every instance the nurses' home has been overcrowded with nurses. However, now that our general hospitals are reducing their student nurse group possibly housing accommodation could be arranged in the residence.

Apparently women are in medicine to stay and their contribution would warrant this premise. Undoubtedly they now suffer a serious handicap, and since approximately 8 to 10 per cent of the graduate body in Canada is made up of women we believe that something should be done in many of our hospitals to increase the number of openings available to women interns.

Dr. MacMurchy Has Capably Served the People of Canada

THERE will be general regret at the retirement of Dr. Helen MacMurchy from her post of chief of the division of child welfare of the department of pensions and national health. During her distinguished career she rendered a considerable service to the people of Canada.

At a time when women in medicine were almost unknown she took her degree in medicine at the University of Toronto. Thereafter Dr. MacMurchy turned her knowledge and her great energy to many kinds of welfare work, particularly to those branches having to do with the better care of mothers and children. Her work in school hygiene and as inspector of hospitals, prisons and charities for the Province of Ontario was a major contribution, as was her service to the children in the federal sphere.

Dr. MacMurchy is a clear and forceful speaker—magnetic and inspiring because of the sincerity and appealing character of her convictions. Moved by a consuming humanity, a horror of waste, disease, dirt, disorder and indifference, she has given practically her whole working life to bettering conditions for women and children and rousing public opinion on their behalf. Essentially a practical woman, possessed of unusual executive ability, her ideals never degenerated into sentimentality. Always the job to be done was the big consideration, and her associates always found she went right to the heart of the problem in hand.

It is fitting that on retiring from the heavy responsibilities of her executive position, Dr. MacMurchy will undertake research work in the promotion of mental health in children, and prevention of mental illness in later life. She will make her home in Toronto.

VICTORIA, B.C.—A farewell dinner and presentation to Dr. E. M. Pearse, medical superintendent of the Provincial Royal Jubilee Hospital since 1922, who is retiring, was tendered on the evening of November 28th, at the Union Club by members of the board of directors.

The gathering was informal and during the course of the evening Mayor David Leeming, a special guest at the dinner, presented Dr. Pearse with a case of pipes on behalf of the directorate. He paid tribute to the sterling work that had been accomplished by Dr. Pearse during his tenure of office and to the cordial relations that had always existed between the medical superintendent's office and the directorate.

Mr. Torrance with Arrow Bedding

Mr. R. C. Torrance, after an association of eighteen years with Simmons Limited, has joined the staff of Arrow Bedding Limited, Toronto. Mr. Torrance will have charge of the hospital lines of beds and bedding in which this firm are specializing.

A Study of Hospital Legislation in Canada

(Continued from page 9)

out interfering with private support and philanthropy.

These are some of our legislative problems to-day. There are others. Our hospitals need greater protection with respect to the floater, the non-resident and the disputed indigent. Hospitals and their staffs should be safeguarded in the case of traffic accidents, perhaps by a statutory lien on any damages awarded. There should be protection against worthless cheques.

But of most pressing urgency is relief from the apparently ever-increasing burden of non-paying patients. Hospitals are willing to assume a reasonable share of loss over such patients, but it is fair neither to them nor to their private patients that they be asked to treat so many patients for a monetary return so far below the actual cost in our larger and better equipped institutions. When the Royal Commission on public welfare made its study of hospital conditions in Ontario recently, it laid down the principle that "non-pay patients in the general hospitals should be a complete charge on public funds." To this principle the writer fully agrees, for otherwise in the vast majority of our hospitals, the patient in the private ward who probably is strained to the uttermost to retain his independence and pay his own way must assume some of the cost of carrying the non-pay patient; and he of all people is the one at that time least able to carry any additional load.

It may be argued, as was suggested by one delegate at the Winnipeg meeting, that charity is the prerogative of the Church and should not be entirely assumed by the State. As a national policy this is certainly open to debate, but even accepting such an assumption, there will still be endless avenues for the exercise of private charity and philanthropy long after this particular claim—that non-pay patients in the general hospitals should be a complete charge on public funds—will have been accepted by the provinces.

Conclusion

When one considers the origins of our hospital system, its early entire dependence upon charity and private philanthropy, with no thought of state support, we realize how far we have gone in the interval. Obviously in this young country with limited families of wealth, without this municipal and state support our hospital system could never have attained its present efficiency.

Most of us feel that hospital legislation does not go far enough. Our governments, however, are in the perplexing situation of having to hold the support of municipal associations and accordingly cannot give us all that we wish or that our governments would be willing to give. Our task therefore is to more fully acquaint our local and municipal leaders of our problems and particularly those problems which can be corrected by legislation. Many hospital workers feel that in these days when the farmer group, the labour group, the manufacturers and others are all exerting a political influence as groups, the time has come when our legions of hospital workers might well exercise their influence towards supporting those who favour health and social advancement.

Frank Roy Davis, M.D., F.A.C.S., New Minister of Public Health, Nova Scotia

In the recent elections in Nova Scotia, Dr. Frank Roy Davis, of Bridgewater, was elected to the Provincial Legislature, succeeding Dr. G. H. Murphy as Minister of Public Health under the MacDonald Government.

The Honourable Mr. Davis, son of the Rev. J. H. Davis, was born in Shelburne, N.S., in 1888. After his graduation from Dalhousie University in 1911, he practised at Petite Riviere, Lunenburg County, for seven years, and has been Medical Officer of Health for Lunenburg County since 1923. During the past fifteen years he has been associated with the Dawson Memorial Hospital, Bridgewater, as surgeon. In addition to his professional duties, Dr. Davis also served Bridgewater as mayor for four years. He is a Fellow of the American College of Surgeons.

Doctor Davis brings to the Cabinet an intimate knowledge of the health problems of the province gained as an active medical officer of health and from his years of practice as a surgeon.

WINNIPEG, MAN.—Dr. C. R. Gilmour was elected to a second year of office as chairman of the Honorary Attending Staff of the Winnipeg General Hospital, at the annual meeting held on Thursday, November 30th, in the board room at the hospital.

Other officers elected were Dr. J. C. McMillan, vice-president, and Dr. C. W. Burns, secretary. Dr. B. J. Brandson presented the report of the advisory committee, and Dr. E. S. Moorhead, the report of the training school committee. Heads of departments also submitted reports on the work in the various departments in the hospital.

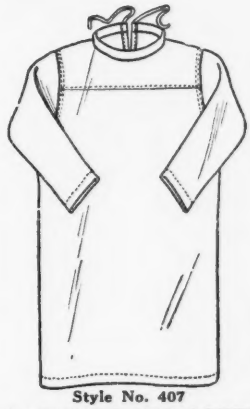
Index to Advertisers

Quality Hospital Apparel

Style No. 442

NURSE'S OPERATING GOWN

Full-length gown with plain front, neat turn-over collar and full-length sleeves. Closes down back with tie tapes, and with long belt stitched on front to tie at back. Can be furnished with knitted cuffs which fit closely and easily into the rubber gloves.



Style No. 407

PATIENT'S BED GOWN

Standard length, 40 inches, closes down back with tie tapes, or linen buttons, if preferred, reinforced with yoke both back and front.

Material Numbers	Description	Prices Per doz.
97	Unbleached Sheeting	$ 6.75
99	Best Quality Unbleached Sheeting	9.00
58	High Quality Bleached Sheeting	9.50
56	Bleached Marble Head	10.50

SURGEON'S OPERATING GOWN

A full-length gown with plain front, standing collar and full-length sleeves. Closes down the back with tie tapes, and with long belt stitched on front to tie at back. Can be furnished with knitted cuffs which fit closely and easily into the rubber gloves.

Style No. 431

Prices on Operating Gowns

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99	Best Quality Unbleached Sheeting	$12.00
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Above prices are for regular cuffs. If required with knitted cuffs add $1.00 per doz.

Prices on Operating Gowns

Material Number	Description	Per doz.
99	Best Quality Unbleached Sheeting	$12.00
58	High Quality Bleached Sheeting	13.00
56	Best Quality Bleached Marble Head	15.00

Above prices are for regular cuffs. If required with knitted cuffs add $1.00 per doz.

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Made of Bleached Marble Head, closed down front with tie tapes. Price $15.00 per doz.

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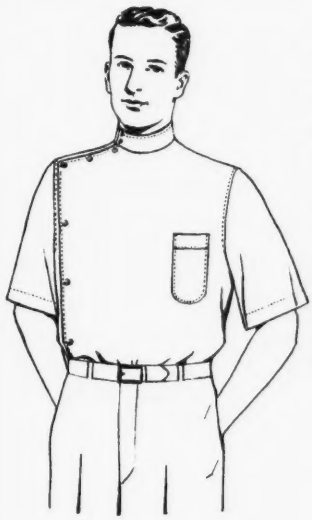
Made of Bleached Marble Head, pyjama style, draw tape at waist. Price $15.00 per doz.

All garments unconditionally guaranteed, as to both workmanship and material.

Quotations cheerfully submitted on Special Apparel for Hospital use.



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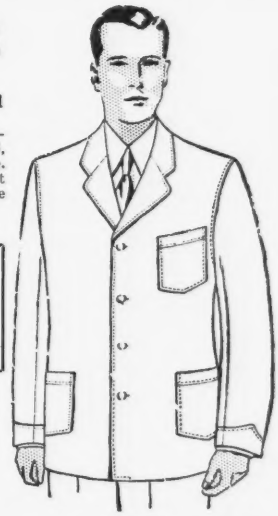
House Doctor's Shirt

Made of the best quality bleached shirting, our No. 65. Price $18.00 per doz.



Style No. 113-79

House Doctor's Coat

Made of bleached drill, this coat is neat and serviceable. It has the lay-down collar, three pockets, detachable buttons and pointed cuff on sleeve. Price for the coat, $24.00 per dozen. Pants to match, $24.00 per dozen.

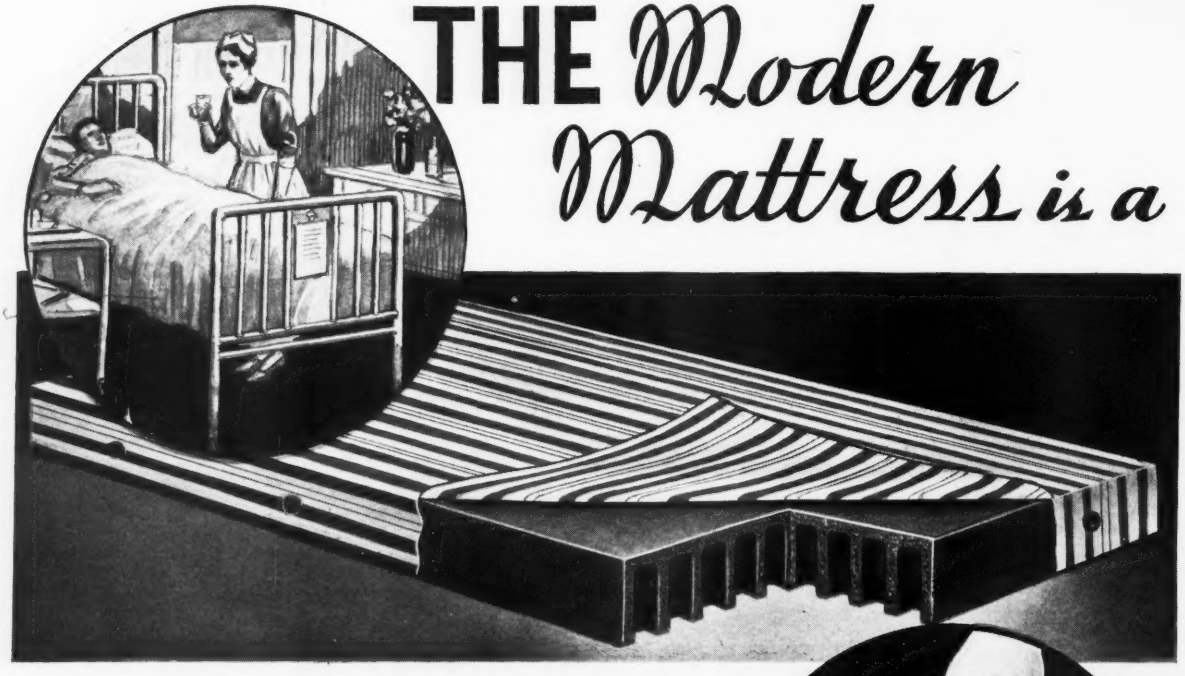
Sales tax is NOT included in above quotations, as same does not apply when garments are shipped to Approved Hospitals under their purchase orders bearing the required Sales Tax exemption certificate.

MADE IN CANADA BY

CORBETT-COWLEY *Limited*

690 KING STREET W., TORONTO 2

637 CRAIG STREET WEST, MONTREAL



THE *Modern Mattress is a*

"DUNLOPILLO" MATTRESS

"Cushions without Springs"

DUNLOP has entirely departed from conventional mattress design in the new "DUNLOPILLO" mattresses . . . . and has evolved a mattress so infinitely sensitive to every variation of pressure that it may be said to actually float the body.

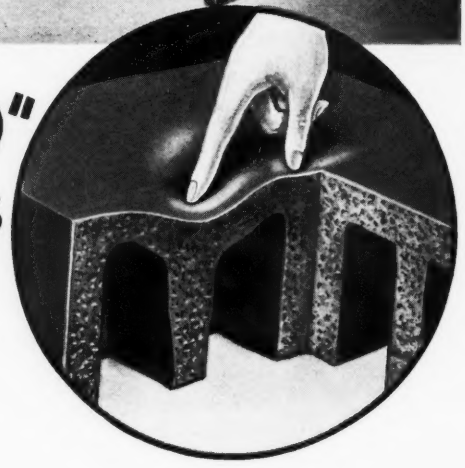
This new "DUNLOPILLO" mattress is made directly from liquid latex. It is in no sense an adaptation of any formerly existing cushioning material, but is made from a totally new material evolved in DUNLOP laboratories.

"DUNLOPILLO" Mattresses are made from a new material in which millions of tiny air cells provide a hygienic, self-ventilating cushion possessing exceptional resiliency. The cells permit of a free circulation of air. Consequently the mattress "breathes" as pressure variations are applied.

This breathing action **cools** the mattress and the minute cells provide an astonishing gentleness of support.

"DUNLOPILLO" Mattresses and Operating Table Cushions, in service in several Canadian hospitals, are proving both their superiority and their economy.

Write for full information to "DUNLOPILLO" Products, Division M, Dunlop Tire & Rubber Goods Co., Limited, Toronto.



"DUNLOPILLO" Mattresses "float" the body on millions of tiny, self-ventilating cells that "breathe."

"DUNLOPILLO" PRODUCTS

Made by

DUNLOP

C A N A D A

Mattresses — Seats
Cushions